CERTIFICATION FORM FOR FOSTER CHILD/GRANDCHILD

This is to certify that I have been informed of the following requirements for coverage of a foster child in the Federal Employees Health Benefits Program and the Option C Family coverage under the Federal Employees Group Life Insurance:

- The child must be unmarried and under the age of 22;
- The child must live with the employee;
- The parent-child relationship must be with the employee, not with the biological parent. This means that the Federal employee exercises parental authority, responsibility, and control, cares for, supports, disciplines and guides the foster child, and makes decisions about the child's education and health care.
- The employee must be the primary source of financial support for the child; and
- The employee must intend to raise the child into adulthood.

I understand that if the child moves out of my home to live with a biological parent, he/she loses coverage and cannot ever again be covered as a foster child unless the biological parent dies, is imprisoned, or becomes incapable of caring for the child due to disability, or unless I obtain a court order taking parental responsibility away from the biological parent.

I have attached proof of my regular and substantial support for _____, who is unmarried and lives with me in a regular parent-child relationship. I intend to raise this child into adulthood. I will immediately notify both my servicing personnel office and my health benefits carrier if the child marries, moves out of my home, or ceases to be financially dependent on me.

_____
Signature of Employee/Date

_____
Printed Name of Employee

_____
Social Security Number